quently confused with a high rectocele. Unless the hernia is pronounced or shows a definite sac containing the bowel, an enterocele, a preoperative diagnosis is difficult.

If the condition remains unrecognized during a perineorrhaphy, the operative result will be disappointing.

In two of the three cases that have come to our attention, a previous perineorrhaphy had been done. In our last case there was an associated uterine prolapse which required a vaginal hysterectomy. Apparently the constant traction of the contents of the hernia tended to drag the uterus with it, and was a factor in producing the prolapse. The action was similar to a sliding inguinal hernia, where the colon is pulled into the canal.

Doctor McCarty's operative technique seems to be universally employed. The detail of attaching the stump of the sac to the posterior surface of the uterus seems of value, and we shall employ it in our future cases. The results from this type of operation seem to be good, and rarely is it necessary to go into the abdomen from above.

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BON O. ADAMS, M. D. (Mission Inn Rotunda, Riverside).—The study of posterior vaginal hernia, which Doctor McCarty has presented, is a very important one, both to the patient and to the careful diagnostician. I, myself, failed to recognize the true condition in the case which the doctor reports—indeed, I had repaired the "rectocele" in this case, some nine years ago, and failed to recognize the true posterior vaginal hernia which was probably present at that time. I considered this case a recurrence of the "rectocele" which I had operated, until Doctor McCarty was able to demonstrate to me at operation the presence of a hernial sac and its contents. The contents were reduced, the sac amputated, and the stump anchored to the posterior uterine wall.

The point of differential diagnosis which should be emphasized is that the finger in the rectum will curve into the rectocele and demonstrate only a two-wall septum; *i. e.*, the anterior rectal wall and the posterior vaginal wall, whereas, if a hernia complicates the rectocele, the interbimanual mass is thicker, and can be felt to impulse on coughing and to gas-gurgle upon bimanual manipulation for reduction of the hernia. The technique of repair has been well described in the paper, and need not be amplified.

We are indebted to Doctor McCarty for his lucid presentation of this important paper upon a condition, the diagnosis of which I am sure I must have missed more than once, and I dare say many others have overlooked at times.

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HALL G. HOLDER, M. D. (233 A Street, San Diego).—I have never seen a true posterior vaginal hernia such as Doctor McCarty describes.

My interest in this subject is in vaginal enterocele. This condition is present in vaginal prolapse in a far larger per cent of cases than is generally recognized, and undoubtedly accounts for many of the poor results in the operative treatment of this condition. It is important, therefore, in the surgical treatment of vaginal prolapse to properly diagnose vaginal enterocele, and it is further necessary that some definite surgical procedure be in mind for its correction in addition to total vaginal hysterectomy. The differential diagnosis may be easily made as so clearly brought out by Doctor McCarty following rectal examination. In cases of vaginal prolapse it has been my practice to employ the Mayo technique of plication of the broad ligaments after total vaginal hysterectomy under the symphysis as a basis for the cure of the cystocele. This procedure has been very satisfactory, as far as it goes, but in addition the treatment of the vaginal enterocele, which is almost always present, should be taken into consideration.

It is very simple at the time of hysterectomy to dissect out the peritoneal pouch of the enterocele herniating through the cul-de-sac of the Douglas up to the uterosacral ligaments. The sac is then ligated, amputated and the uterosacral ligament tied with interrupted silk sutures as close to the rectum as possible. The vaginal incision is then closed in the usual manner and high perineorrhaphy completes the operation. I believe Doctor McCarty's paper is timely in emphasizing the importance of diagnosis and proper surgical treatment of a condition which is frequently overlooked, and which is probably the prime factor in poor results, and recurrence of herniation and prolapse in these cases.

MENTAL HYGIENE VIEWPOINTS ON SOME COMMON PEDIATRIC PROBLEMS*

By FORREST N. ANDERSON, M.D.
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DISCUSSION *by George B. Kryder, M. D., Glendale; E. Earl Moody, M. D., Los Angeles; Ernst Wolff, M. D., San Francisco.*

AT the outset of this discussion I shall try to define my position. Under the general heading of psychiatry there are two rather widely different concepts. Unless we understand by the context which of the concepts is meant, we are left in confusion. I refer, first, to the concept of psychiatry as a definite technique—in a rough way approximating the techniques of surgery, obstetrics, or any other medical specialty. To try to disarm your criticism, I admit immediately that my specialty is less tangible in its techniques than are these others, but I am going to assume your agreement to the general idea that psychiatry does have a technique.

The other concept of psychiatry is in its attitude sense, such as may be implied in the expression, "He has a good psychiatric viewpoint." It is this concept upon which I am dwelling today. It is the meaning and value of psychiatry that is worth while to other physicians, and more especially to pediatricians. It is a something that is not, by any means, the sole possession of the psychiatrist; nor is it his contribution alone to medical and educational approach and philosophy. As I see it, the psychiatrist is entitled to call this his province and his contribution mainly because he has made of it an object of thoughtful and prolonged consideration. He has, in a sense, endeavored to codify and extend the principles, all the while admitting the integral contribution of the pediatrician, the physiologist, the educator, the social worker, and others. I trust I make clear my meaning.

ATTITUDE OF MENTAL HYGIENE PSYCHIATRY

Now what is this attitude of mental hygiene psychiatry, and on what is it founded? We have evolved in our philosophy to the place that we realize that, to most questions, we do not have specific answers. We have learned that neither medicine nor any other technique can, except in a relatively few instances, materially alter the phenomena of life. We have learned that man as a time-space binding organism is a temporary focalization of forces almost cosmic in intensity, and that what we mainly may do is to ascertain principles and methods of these forces in action. Then, perhaps, we may push our patient just a little more in line with the main channel of these processes. In other words, we study not to alter nature, but to know, and put ourselves in harmony with her.

We have come to realize that the child is not separable into components of body, emotion, and intellect. These are still helpful pigeonholings, so long as we always bear in mind that what we are dealing with is not a divisible organism but a unit-functioning one. As cases passing by us and

* Read before the Pediatric Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

through our hands, we see school conduct improved by physical treatment, and bodily health improved by parental attitudes. As we have this kind of experience we begin to grasp, in a practical way, what is meant by this concept that the individual is forever indivisible and unanalyzable into separately acting components.

PHYSIOLOGICAL BASIS

As we turn attention to the present-day development of knowledge of the basal ganglia region of the brain—the hypothalamic and pituitary areas—and their importance to visceral and emotional aspects of the child, I think we are seeing more clearly that we already have a fairly secure physiological basis for our contention that when we treat the psyche or the body, we are treating the whole organism. You pediatricians know what encephalitis has shown us concerning the organic substrata of emotion. You know that injury of an apparently nongross character seems sometimes to produce personality changes. We, in psychiatry, are coming more to believe that long-continued exposure to attitudes and management may induce changes in this area that are as essentially organic as are those occurring in disease or in trauma. Less dramatic, I admit, but probably equally important. The spoiled child may be as truly conditioned, in an organic sense, by his experiences as is the obviously sick child. Likewise, the well-trained youngster has his experience incorporated into the neuron pattern of his deeper brain layers, and depends on this for his continuity of acceptable behavior. As I like to express it, we have probably sufficient evidence of the importance of this zone to have us accept the viewpoint that the physiology and psychology of a child are essentially indistinguishable.

SOMATOPSYCHIC DEVELOPMENT OF THE CHILD

So much for the underlying philosophy. Now for consideration of the somatopsychic development of the child, to see wherein we may find helpful viewpoints in that great intermediate zone where pediatrics as a technique, and psychiatry as a technique, merge their experiences through a common viewpoint or attitude.

The child at birth we view as an organism operating on an instinctual or emotional basis. Reason, knowledge, and consciousness are to all intents and purposes nonexistent. He responds on a feeling level. He lives his experiences on that level. He learns to *feel* his parents, and his more immediate physical and personal environment. He eats, sleeps, and fondles on a basis of satisfaction or physiological feeling. He initiates reactions that we all consider normal. Some of these will later bring him into conflict with his environment. Such are reactions of bladder-emptying, finger-sucking, ways of eating, response to person and control, etc. He lays the ground plan of his most important daily activities. I repeat, we all recognize this as normal. It is the response in manifold ways of an unthinking psychobiologically healthy organism.

INTERFERENCE ELEMENTS

Within a short time we, in the person of parent, nurse, or physician, lay interfering hands on these heretofore smoothly functioning processes. We *act* our interference by demand, by prohibition, and by attempted authority. In the sense of our greater knowledge of the child's necessary later social adaptations, no serious arguments can be urged against what we do. But the child does not have this forevision that we do. We have no way to tell him effectively. In the main, we actually do our training at a level that he does not knowingly understand, but that he does apparently feelingly grasp. We deal with him by gesture, manner, tone, affection, threat. All of these are counters in the language of feeling that has value to him from the day of his birth. To a surprising degree we influence him. So much is this the fact that we now believe that we have learned that training or discipline must be on that level on which it is naturally effective. To point out to a youthful thumbsucker that he may be jeopardizing his facial symmetry and his mouth-functioning, is likely to be without habit-changing effect. The repetitious pointing out of this fact—commonly called common sense by the parent, and nagging by the child—usually accomplishes little. Often it intensifies the habit. The same seems to be true of physical prohibitions by force. I hasten to assure you that I am not one who opposes the decision by the parent or the physician to overcome a habit in a child or to fight it out until both parties are willing to call it a draw. But I do think the decision should be made after careful consideration of the pros and cons—of the likelihood of its effectiveness, of the antagonisms that may be aroused, of the motivations toward habit continuance that may be stimulated. If, after this, the guardian feels that he must make an issue, that is his right. It will sometimes happen that his very sureness of carefully deliberated and determined decision will carry conviction to the child and solve the problem. But I do deprecate the traditional giving of advice to stop habits, without realizations of the deeper-lying processes with which we are dealing.

TROUBLESOME CHILDHOOD HABITS

This viewpoint applies to all these troublesome childhood habits—enuresis, masturbation, eating, sleeping, tantrums, etc. They are reactions in themselves not abnormal. They are not diseases. They involve a physiopsychological response in a growing organism to feeling stimuli. This means they are not superimposed somethings that can be shed by an effort of knowledge or even of the will. They are expressions, undesirable to be sure, of the total child which is as much a part of him as his ways of reacting to parents, to school, or to friends. To change them means motivating the child. If we can strategically modify the situation to help motivate him to these habit alterations, he will often change his habits. It will sometimes happen that we can use pituitary or thyroid substances for enuresis, or thumb guards for sucking propensities, but these become meaningful adjuncts or methods utilized on a sound basis of motivation within the child. To our way of thinking, this is far apart from the use of medicine or appliance as a treatment *per se* of a disease. It is analogous to our present realization that reading is a tool of life and not a thing in itself to be learned as a separate

task, as was the case in the childhoods of so many of us. We today think reading is quite as important as did our fathers, but we have evolved to a philosophy that looks upon its place in the educational scheme as really quite different from theirs. As we have done this, not only has methodology changed somewhat, but I believe our children have imperceptibly imbibed a newer viewpoint toward it.

COMMENT

Now this is not concrete. I do not mean it to be. I find myself often remembering that I have less sympathy with concrete solutions of problems than I formerly had. This may be a defense reaction. Naturally, I believe it is because I see medicine and education in a light more meaningful and more philosophical than when I thought in terms of specifics. To me the meaningfulness of childhood and adult reactions is a more worth while study than is empiric prescription. I realize that parents frequently want specifics. I have tried to conquer the urge of trying to give specific answers. I am convinced that the old course is charged with more dynamite than the slower process of attempting to see what the purposefulness of the symptom may be. We advanced in the treatment of fever when we came to realize that there was often a beneficent reaction—painful as a symptom, but meaningful as to what was going on. We seldom treat fevers as such any more. Thus, in mental hygiene psychiatry, thumbsucking and bad eating habits are essentially on the same level as is fever. We are not always able to find specific causes of either the one or the other. But at least we have the orientation of looking beyond the symptom, and even if we are compelled to treat it as a symptom, still we no longer regard it as a disease.

IN CONCLUSION

In this and many kindred ways pediatrics and psychiatry are merging their efforts, and who can say for certain any longer where the dividing boundary is? I think that we in psychiatry should know much more of the accepted field of pediatrics, just as we should of endocrinology and other related areas of knowledge. But we cannot know all this. We have to acknowledge the specialized fields of medicine. We can assist in the construction of a platform where all of us may meet. This platform is one of viewing the body, the mind, and the environment as one—mutually interacting aspects of a continuously growing, changing unity. Onto this platform the psychiatrist need not carry his jargon of orthodox tradition. He ceases being concerned primarily with the abnormal. Nor need the pediatrician carry all of his techniques there either. The two may meet in consideration of the growth problems of the child. They can meet with still others, for there is a common denominator, an attitude of seeking the meaningfulness of behavior, and of relating this to the total functioning of the child.

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DISCUSSION

GEORGE B. KRYDER, M. D. (Professional Building, Glendale).—Pediatricians are becoming more and more conscious of the need of more closely combining the psychological with the physical care of children.

A few years ago Dr. Joseph Brennemann wrote a paper with the ominous title, "The Menace of Psychiatry," in which he contends that the obvious solution to the state of confusion of theory and authority, produced by the various schools of psychiatry, would be the advent of the "pediatric psychiatrist or the psychiatric pediatrician."

Since then, the development of mental hygiene psychiatry has more or less overshadowed the various schools of thinking by viewing the child as an indivisible unit, rather than considering it as a separate unit of mind and matter.

This viewpoint is looked upon with favor from the pediatrician, inasmuch as it is workable and permits him to use it in his everyday practice.

However, we cannot expect to learn all about the subject, but the popularity of mental hygiene psychiatry is a direct challenge for us to search further into this subject, as an aid in the prevention and relief of personality disorders.

Pediatricians have the privilege of constant observation and supervision of babies and children in their formative years. Too often we take for granted the child who does not register in our minds as a "problem child." We should realize that nearly every child is a candidate for a personality disorder, if it were motivated by the wrong kind of environment, and that the earlier we can establish patterns of psychologic wholesomeness, the better the chance of the child developing into an individual who can adjust himself easily to the world about him.

Mothers should be taught, early in the child's life, the evils of improper management, and particularly advised during the period of domestic socialization. It is during this period, when habit training is most effective; when negativism is to be combated and when the rights of others are to be realized. It is then that the attitude and conduct of the child can be developed along normal natural lines, or hindered by unwise parental management.

Pediatricians can learn much from the systematic manner of approach to behavior problems which the guidance clinics have given us. More painstaking devotion to details of family, home and school environment will more often give us an insight into the motivating factor in personality disorders.

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E. EARL MOODY, M. D. (3780 Wilshire Boulevard, Los Angeles).—The statement of Doctor Anderson, that the physiology and the psychology of a child are essentially indistinguishable, and that behavior patterns are conditioned, in the organic sense, in the deeper layers of the brain, is startling. Yet, we who observe children grow and develop their behavior through their early years, must certainly realize that this is so. I believe firmly that the personality pattern is going to be rather a fixed thing after a few short years of the child's life. What an opportunity we pediatricians have in shaping this pattern of our little patients!

I like to tell parents that we cannot do much about the heredity of the child, once it is here, nor can we change its intelligence. We can, however, do a great deal in shaping the environment, so that the various stimuli coming from this environment and playing upon the child shall awaken the proper responses. I believe that a few basic emotions born with the child, a few instincts which are of relatively little importance, and the intelligence make the pablum that is to be shaped by its environment into a creature of habit. Should we not see that these responses are good, instead of bad?

How relatively simple it is with the average parent, whose whole life is wrapped up in the child, to direct his attitudes so that the child becomes conditioned in a good way. Certainly, if we accept this viewpoint, it is just as easy to develop a good habit in the receptive child as to develop a bad habit. The mechanism of development of good and of bad habits is the same. Thus, if good habits are developed and the child is taught to make his social adjustments, day by day, with good habits of action, we need not fear the child's ability to handle the complex problems of life as he advances to adolescence and adultness.

I believe that we pediatricians do not take enough time with the young parent during the early weeks of the child's life to discuss these problems. I consider the first few weeks of a child's life to be the most important of all childhood. Here the personality-pattern is started. During this period the pediatrician should spend much time getting the parents to "view the body, the mind, and the environment as one";

the forces that will shape the child's whole existence. I admit that often one feels that efforts are useless, for one is so frequently confronted with parents whose personality, patterns, and habits of action are such as to render them unfit for parenthood. Fortunately, these are few. The average parent, in my experience, is ready and willing to accept this viewpoint, and makes a coöperative assistant in our efforts to shape the behavior and adjustments of the child.

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ERNST WOLFF, M. D. (450 Sutter Street, San Francisco).—Doctor Anderson's paper, in its simplicity and breadth, is an admirable exposé of dynamic psychology as it applies to pediatric problems. Even more than new knowledge, its practical application demands new attitudes. For pediatricians must acquire not only an objective familiarity with psychological factors pertaining to the child in its setting, but, more important, he must vitalize this knowledge through his own development, and through his self-understanding. Only through self-development can he exercise such influence over parent and child that whatever helpful advice he may give is actually put into effect, and the contact with him as a personality will in itself be a maturing experience for parent and child.

The organization of pediatric work needs to be built up so that there is an integration of mental hygiene concepts into the field of prevention and treatment. This means a combined psychobiologic approach to prenatal, well-baby, and preschool clinics, and into the pediatric wards. In the same way diagnosis and treatment of childhood diseases should be based on the consideration of functional and organic factors simultaneously.

Thus the scope of pediatrics will be extended, and the pediatrician will come in an advisory capacity into the field of progressive education.

ACUTE IRITIS: ITS TREATMENT*

By FRANK H. RODIN, M.D.
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DISCUSSION *by George H. Kress, M. D., Los Angeles; Samuel A. Durr, M. D., San Diego; Alfred R. Robbins, M. D., Los Angeles.*

LEAVING out of consideration trauma to the eye and foreign bodies in the eyes, the only eye conditions which demand emergency treatment are acute glaucoma, conjunctivitis due to the gonococcus, serpiginous corneal ulcers, and acute iritis. Delayed and improper treatment of acute iritis may be disastrous to the eye.

THE IRIS

The iris is a disc-like membrane perforated in its center by the pupil and attached by its distal border to the ciliary body. The iris lies on the lens. When stimulated by light the pupil contracts. This reaction is most active in young people, and not so active in older individuals. There are certain conditions where the pupil does not react to light, such as: Argyll Robertson pupil, atrophy of the iris, acute glaucoma, and acute iritis. When the iris is seen in good light, or, still better, with a magnifying glass, delicate markings are seen on its anterior surface, which are made up by the blood vessels lying in the stroma of the iris.

IRITIS AND IRIDOCYCLITIS

Iridocyclitis is an inflammation of the iris and the ciliary body. Fuchs [1] states: "Unmixed inflammation of the iris (iritis) is rare; in most cases we have to do with a combination of the two (iridocyclitis)." In this article it will be considered as iritis.

TABLE 1.—*Differential Diagnosis Between Ciliary and Conjunctival Injection (Table After May)*

Ciliary Injection (Deep)	Conjunctival Injection (Superficial)
1. Derived from the anterior ciliary vessels.	Derived from the posterior conjunctival vessels.
2. Accompanies iridocyclitis, deep inflammations of the cornea, and may accompany severe conjunctival inflammations.	Accompanies conjunctivitis.
3. Lacrimation, but no discharge.	Lacrimation and some discharge.
4. Consists of hyperemia of episcleral network of capillaries and veins.	Composed of a network of superficial tortuous vessels, which are easily recognized.
5. Cannot be displaced with the movements of the conjunctiva.	Can be moved with the conjunctiva by pressure of the lower eyelid.
6. Most marked around the cornea (circumcorneal injection), and diminishes toward the retrotarsal fold.	Injection diminishes from the retrotarsal fold toward the cornea.
7. Pink, violet-red color.	Bright, brick-red color.
8. Epinephrin has very little effect on the ciliary injection.	Epinephrin causes blanching of the conjunctival injection.

SYMPTOMS OF IRITIS

The symptoms vary. The eye may be very painful, or the pain may not be very prominent. Photophobia and lacrimation are usually present. The vision may be impaired. The usual signs are: some edema of the margins of the eyelids, especially the upper eyelid; ciliary injection, sometimes intense injection of the whole eye. The eye is tender. The iris is swollen, and the fine markings so well seen in the normal eye are not so distinct and may even be obliterated. The color of the iris may be changed by the invasion of exudate and blood. The pupil becomes small and does not react to light, or reacts to light poorly. There may be posterior synechiae. Hypopyon may be present, and fine precipitates are thrown out on the posterior surface of the cornea. The picture varies with the intensity of the infection and the general condition of the patient.

The sequelae are: posterior synechiae, seclusion or occlusion of the pupil, atrophy of the iris, plastic exudates in the vitreous, secondary glaucoma, and secondary cataract.

DIFFERENTIAL DIAGNOSIS

Acute iritis has to be differentiated from acute catarrhal conjunctivitis and acute glaucoma. In differentiating acute iritis from acute catarrhal conjunctivitis, the type of injection of the eyeball is of great importance. Since the bulbar conjunctiva is supplied by vessels from two sources we have to consider the two types of injections: conjunctival injection and ciliary injection. Table 1 describes the two forms. In its pure form, where

* From the Department of Ophthalmology, Mount Zion Hospital.

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